State of Maryland – Department of Health and Mental Hygiene

Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists

4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 Fax 410-358-0273
TTY/Maryland Relay Service 1-800-735-2258

Speech-Language Pathologist Full License Application

Date _____ **Affix current 2x2 passport size photo**

1. Name _____
Last First Middle/Maiden

2. Home Address _____
Street Apt.

_____
City State Zip Code

3. Home Phone_____ Alternate #_____ Email_____

4. Date of Birth _____ Social Security # _____

5. Have you previously been licensed in the State of Maryland? _____ Yes _____ No

If yes, License # _____ Date Expired_____

6. Have you ever been convicted of a felony or a misdemeanor involving moral turpitude?

_____ No _____ Yes

If yes, please provide detailed explanation on a separate sheet of paper and attach it to the application as well as court documentation.

7. **Education**

Graduate School _____

Address _____
Street City State Zip Code

Attended _____to_____ Major_____ Date Degree Awarded _____

_____

For Office Use Only

Received _____ CH( ) MO ( ) Number _____

Undergraduate School _____

Address_____
Street City State Zip Code

Attended _____to_____ Major _____ Date Degree Awarded _____

8. Do you hold, or have you ever held, the American Speech-Language Hearing Association Certificate of Clinical Competence in Speech-Language Pathology? ____Yes _____No

If Yes, date originally granted _____

(A) Clinical Fellowship Year completed? _____ Yes _____ No

(B) Praxis Examination in Speech-Language Pathology Passed? _____ Yes _____ No

Note: If applicant has not taken the Praxis examination the individual is not eligible for a full license in speech-language pathology.

Note: If applicant does not have ASHA Certification, a certified official transcript showing credit hours in speech-language pathology must be sent directly from the graduate institution directly to this Board.

If you answer no to #8(A) or (B) enclose a professional resume. If you hold a CCC, proceed to # 11. A photocopy of ASHA Certificate or Letter from ASHA must accompany the application.

9. Employment during Clinical Fellowship Year – submit a Form AS2 for each place of employment during the period of limited licensure.

Date _____ Title of Position _____

Facility/Company Name _____

Address _____
Street City State Zip Code

Brief description of duties

_____

_____

_____

10. Supervision of Clinical Fellowship Year

A. Submit Verification of Supervision for Limited Licensure Clinical Fellowship Year (From AS2) or copy of ASHA CFY

B. Submit Verification of Satisfactory Completion of Clinical Fellowship Year (Form AS3)

11. Are you now or have you ever been licensed in any other state? _____ If yes, please complete the first page of the Licensure Affidavit (AS4). Request the State Licensure Board to return the completed form to the Maryland Board office.

I am licensed in the following states _____ _____ _____ _____ _____ _____ _____

I was licensed in the following states _____ _____ _____ _____ _____ _____ _____

12. Has any disciplinary action ever been taken against any license you have held in any other jurisdiction?

_____ No ____ Yes

If yes, please provide a detailed explain on a separate sheet attached to this application.

13. Have this Affidavit completed by a Notary Public

I hereby affirm that I have read Sections 2-101 to 2-502 of Title 2 of the Health Occupations Article of the Annotated Code of Maryland and fully understand that in receiving a license from the Board, I bind myself to be governed by the Board.

I understanding that in submitting this application that the accompanying fee is for administrative purposes and is not refundable. The fee includes licensure fee.

State of _____ ***City/County of*** _____

The undersigned, being duly sworn, deposes and says that he/she is the person who executed this application, that the statements herein contained are true to the best of his/her knowledge, that he/she has not suppressed any information that might affect this application and that he/she has read and understands this affidavit.

_____ _____

Signature of Applicant Signature of Notary

Subscribed and sworn to before this _____ day of _____

****

In accordance with Executive Order 01.01.1093-18, the Board is required to advise you as follows regarding the collection of personal information:

> Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee's identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary.
>
> Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

****

Race/Ethnic Identification

To further its commitment to equal access the Board of Examiners requests applicants to provide, voluntarily, the following information. This information will be used for statistical purposes only by authorized personnel.

Male _____ Female _____

Race/Ethnic Identification – Please Check All That Apply

Are you of Hispanic or Latino origin? ____ Yes ____ No (A person of Cuban, Mexican, Peurto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ___ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

2. ___ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

3. ___ Black or African American (A person having origins in any of the black racial groups of Africa.)

4. ___ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

5. ___ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

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Verification of Supervision for Speech-Language Pathology Clinical Fellowship Year

1. Applicant (Please type or print)

A. Name: _____
Last First Middle/Maiden

B. Address: _____
Street Apt.

_____
City State Zip Code

Phone: _____ Alternate # _____ Email _____

C. Academic Status: _____
College Degree Date Awarded

D. Employment Setting:

1. Facility Name: _____

2. Street Address: _____

_____
City State Zip Code

Phone: _____ Fax: _____

3. Beginning date of employment: _____
Month Day Year

4. Hours per week spent in Speech-language Pathology? _____

5. Is applicant completing a CFY? _____Yes _____No

Form AS2

II. Supervisor of Limited Licensure year (please print or type)

A. Name: _____
Last First Middle/Maiden

B. Street Address: _____

_____
City State Zip Code

C. Place of Employment: _____
Facility Name

_____
Street

_____
City State Zip Code

Phone: _____ Alternate #_____

III. Clinical and Supervisory Responsibility

Applicant Activity	**Hours/Week Spent by Applicant**	**Hours/Month Spent by Supervisor**	
		On-Site Observation (at least 4 hour per month)	**Other Monitoring Activities (optional)**
1. Assessment, diagnosis and/or evaluations			
2. Screening			
3. Habilitation/ rehabilitation			
4. Staff Meetings			
5. Supervisory Conferences			
6. In-Service Training			
7. Record Keeping			
8. Other (Must Specify)			
Total			

Signature of Applicant _____ Date _____

Signature of Supervisor _____ Date _____

Supervisor:

( ) Holds ASHA CCC-SLP, ASHA Certificate # _____

( ) Holds MD License in Speech-Language Pathology, License # _____

( ) Holds License in Speech-Language Pathology in State of _____

Form AS2

Revised 10/2016

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Verification of Satisfactory Completion of Speech-Language Pathologist Clinical Fellowship Year

I hereby declare that _____
Name of Applicant

of _____
Street City State Zip Code

an applicant for Maryland licensure in speech-language pathology, was employed as a professional in that field from _____ to _____ for _____ hours per week.
mm/dd/yyy mm/dd/yyyy

The place of employment was _____
Facility Name

_____
Address City State Zip Code

I further declare that the applicant was supervised by _____
Name of Supervisor

At that time the CFY supervisor held (must be at least one of the following):

( ) Maryland License in Speech-Language Pathology License #_____

( ) ASHA Certification in Speech-Language Pathology Certificate #_____

( ) A License in Speech-Language Pathology from the State of _____ whose licensure requirements were equivalent to ASHA certification.

I verify that during the employment period, the applicant reached a satisfactory level of competence in the area in which licensure is sought.

_____
Signature of Supervisor

_____
Typed or Printed Name

_____
Title

_____ _____
Date Current Phone Number

Form AS3

Revised 10/2016

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Licensure Board Affidavit

This portion of the form is to be completed by the speech-language pathologist. Would you please verify the license in your jurisdiction for:

_____
First Name Middle Name Last Name

Date of Birth _____ Social Security Number _____

Graduate of _____ Date _____

****

This portion of the affidavit to be completed by the Licensure Board.

License No. _____ Date Issued _____

With State Examination _____ Without Examination _____

Is license in good standing? _____ Expiration Date _____

Has the license ever been suspended or revoked? _____ If yes, please explain why: Attach a separate sheet

Has the license been reinstated? _____

Has any disciplinary action been taken against the licensee? _____ If yes, please explain:

_____

_____

Is there any derogatory information on file concerning this licensee? _____ If yes, please explain:

_____

_____

Signature _____ Date _____

Title_____

Affix Board Seal Here

State Board Name _____

State of _____

Revised 10/2016